

VERITA

IMPROVEMENT THROUGH INVESTIGATION

**Independent audit to review the NMC's handling of
documentation relating to midwives at Furness General Hospital**

A report for
Nursing and Midwifery Council

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1. Introduction

1.1 Concern was raised about a number of deaths at Furness General Hospital leading to the establishment of the Morecambe Bay Investigation in September 2013, led by Dr Bill Kirkup. In May 2018 the Professional Standards Agency published a 'Lessons Learned Review' into the handling of concerns relating to the fitness to practise of nurses in Furness General Hospital (now part of the University Hospitals of Morecambe Bay NHS Foundation Trust) by the Nursing and Midwifery Council (NMC). Amongst other issues, the report identified problems with the handling of a document produced by the father of one of the babies who died at Furness General Hospital.

1.2 In August 2018, the NMC commissioned Verita to carry out an independent audit to review the way the NMC handled the chronology. The audit was asked to focus on the NMC's systems and processes in order to establish what happened to the chronology and to identify learning for the NMC from the case.

1.3 Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries. Peter Killwick and Kieran Seale carried out the investigation which was supported by Bethany Simpson. David Scott has acted as peer reviewer. Biographies of the team are included as Appendix A.

2. Terms of reference

2.1 The following are the main elements of the terms of reference for the investigation. The full terms of reference are in Appendix B:

The NMC wishes to commission an independent audit to review the way it handled the chronology. The audit will focus on the NMC's systems and processes in order to establish what happened and to identify learning and opportunities for improvement.

The desired outcomes of the audit are:

1. To explain what happened to the chronology between the points at which Mr A (i) signed his witness statement in May 2010; and (ii) provided a copy of the chronology during the 2016 hearing.
2. To make recommendations for improving the NMC's approach to records management.
3. To explain how any inconsistent and/or ambiguous accounts of what happened to the chronology came to be given publicly after the 2016 hearing.
4. To make recommendations to ensure accounts given publicly are accurate, transparent, and consistent.

3. Summary and conclusions

Introduction

3.1 Following a number of concerns being raised about deaths at Furness General Hospital¹, the Morecambe Bay Investigation (also known as 'the Kirkup review') was established in September 2013. The Professional Standards Agency published a 'Lessons Learned Review' into the handling of concerns relating to the fitness to practise of nurses at the hospital by the Nursing and Midwifery Council (NMC) in May 2018. Amongst other issues, the report identified problems with the handling of a document produced by Mr A, the father of Baby A, one of the babies who died at Furness General Hospital. We refer to that document as 'the Chronology'. In particular there were concerns that the NMC had not accurately described what it had done with the Chronology.

3.2 In August 2018, the NMC commissioned Verita to carry out an independent audit into review the way the NMC handled the Chronology. The audit was asked to focus on the NMC's systems and processes in order to establish what happened to the Chronology and to identify learning for the NMC from the case.

3.3 The investigation team carried out interviews with current and past NMC staff and reviewed documentation supplied by the NMC and others.

Summary of Findings

3.4 The events described in this report led to a bereaved parent who was performing a public duty in appearing as a witness at a fitness to practise hearing being unfairly attacked in the press. This is clearly unacceptable.

3.5 The evidence shows that the events occurred as a result of a series of mainly accidental factors, combined with poor communication and management. The key steps were:

¹ Now part of the University Hospitals of Morecambe Bay NHS Foundation Trust.

- The failure by Capsticks (a legal firm) to include the Chronology in the original case file they sent to the NMC
- The NMC's failure to notice that the Chronology wasn't attached to the statement
- The handling of the fitness to practise hearing, including the lack of respect shown to the bereaved family
- The subsequent failure of the NMC to communicate clearly and accurately with Mr A, the PSA and the Secretary of State.

3.6 The mislaying of the Chronology - the system used at the time to control important documents was clearly unsatisfactory. It is not surprising that it led to the loss of documentation. Capsticks should have allowed Mr A to review his statement earlier and they should have ensured that the NMC had the correct documentation.

3.7 The NMC's failure to notice inadequacies in the documentation - the NMC should have checked the documentation carefully to ensure that it was complete. The long delays in this case from the initial incident and taking of statements to the fitness to practise hearings is an important causal factor in this.

3.8 Events at the hearing - counsel for one of the midwives should have been more careful in attacking the NMC's evidence. The NMC should have prepared better to refute the point about whether the midwives had been told that Mr and Mrs A were feeling unwell, which was the central one in the hearing. We have recommended that the panels at hearings are reminded of the importance of ensuring that witnesses that have suffered bereavement are treated fairly and respectfully.

3.9 Failures of communication by the NMC - subsequent to the hearing, the NMC entered into correspondence with Mr A, the PSA and, ultimately, the Secretary of State for Health, during which the question of the Chronology arose. By this time, the importance of responding clearly and accurately to the points being raised on this issue should have been obvious. While we have identified a series of failures around the administration of Mr A's Chronology in the preceding years, it does not excuse the reality that the simplest errors of fact were made in the NMC's responses. The seriousness of these letters should have prompted sufficient checking so that their accuracy was beyond question.

Conclusions on the NMC's role and culture

3.10 It is important to recognise that the NMC's primary duty is to fulfil its statutory role to determine whether nurses and midwives are fit to practise. Nevertheless, in carrying out our work we have seen strong evidence to support the PSA's view that the NMC failed patients and families in some cases. By overly focussing on process, and not acting with an appropriate level of care and compassion, little or no room was left for a proper consideration of the needs of Mr and Mrs A.

3.11 We note that changes have already taken place to address the issues that arose in this case.

3.12 The NMC's processes for the use of external lawyers have changed and, as documents are now handled electronically, and the standard practice is to return reports only when signed witness statements have been received, the same issue of poor document control is unlikely to recur.

3.13 The changes that the NMC has announced to the way that it deals with patients and families is very welcome. Some of the correspondence we have seen from 2009 - 2014 was totally unsuitable in tone for being sent to a bereaved parent. If one of the outcomes of this case is that NMC staff deal better with bereaved families in future, that would be very welcome.

3.14 It is noteworthy that, in our interactions with the NMC in conducting the audit and in compiling this report, we have been afforded unfettered access to any document and member of staff that we have deemed necessary. We have also been given every assistance in contacting former NMC employees.

In conducting this audit, we did not generally witness the issues in communication and culture that underpin many of the historical failings described in this report. We believe that this is positive, as it is tangible evidence that lessons have been learned. We believe that the organisation's approach to these issues has significantly improved. It is essential that the NMC take the findings of this report, and PSA report published last year, with the utmost seriousness and ensure that necessary changes are embedded across the organisation.

4. Approach and structure

Approach

4.1 The investigation was undertaken in private. It comprised of formal interviews and an examination of documentation.

4.2 Interviews were carried out face-to-face. We sent each interviewee a letter of invitation, a guide for interviewees and the terms of reference for the investigation. We followed established good practise in conducting the investigation by offering interviewees the opportunity to be accompanied to interviews. Most interviews were recorded and transcribed. The transcripts were shared with interviewees so that they could comment on them and clarify any issues arising. A list of those interviewed is at Appendix C.

4.3 We reviewed documentation supplied by the NMC and several other sources. The NMC gave us full, unrestricted access to their electronic filing system and retrieved archived paper files relating to the cases, although we would echo the comments made by the Professional Standards Agency about the completeness of the NMC's records, particularly those that are older. We were also provided with documents by Capsticks Solicitors and Blake Morgan solicitors from their files. A list of the main documents that we considered is at Appendix D.

4.4 Following completion of our draft report we circulated copies to the NMC, Mr A and those people who are criticised in it. During that process we were asked by the NMC to look in more detail at the compilation of the series of letters discussed in section 9 of this report. In order to do that, the NMC made approximately 3,000 email chains available to us, based on search terms that we provided to them. We reviewed these emails and carried out further interviews. We have added evidence from those emails and interviews to this report.

4.5 We have made comments and recommendations based on our interviews and the information available to us to the best of our knowledge and belief.

Anonymisation

4.6 We have used the same approach to anonymisation and the same anonymisation key that was used by the Professional Standards Authority for its review.

Structure

4.7 The report is divided into sections. Section one is the introduction and section two provides an overview of the terms of reference. Section three contains the executive summary. The approach and structure for this report is set out in this section (four) and the next section (five) gives background to the issues discussed in the report.

4.8 The events described in this report are complex and took place over a long period of time. We have therefore divided them into four parts for ease of reading:

- The referral of the case to the NMC and the review by Capsticks - 2009 to 2010 (section six)
- The period of the inquest and work undertaken by Morgan Cole (now Blake Morgan) solicitors - 2011 to 2014 (section seven)
- The lead up to the hearing for Midwives 1 and 2 - 2014 to March 2016 (section eight)
- The period after the hearing - March 2016 onwards (section nine).

4.9 In the last section we set out our conclusions and recommendations.

4.10 Our findings from interviews and documents are set out in ordinary text. Our comments and opinions are in *bold italics*.

5. Background

5.1 Our terms of reference are specific and focus on the handling of a particular document - 'the Chronology' - which was prepared by Mr A. Nevertheless, it is important to understand some of the background to Mr A's case in order to explain events relating to the Chronology.

5.2 The Morecambe Bay Investigation was an independent investigation set up by the Department of Health in September 2013 to look at a number of deaths of mothers and newborn babies at Furness General Hospital. The investigation was conducted by Dr Bill Kirkup CBE and the report was published in March 2015. It found serious concerns about clinical competence and the integrity of the midwifery unit at the hospital.

5.3 Subsequent to the investigation, the Secretary of State for Health asked the Professional Standards Authority (PSA) to undertake a 'lessons learned' review of the way the NMC handled the concerns relating to midwives. That report was published in May 2018. The scope of that review was much broader than ours, but it did also examine the issue of the Chronology in some detail. The evidence that we have found is consistent with the PSA's findings, both with regards to the facts, and with their commentary on problems with document handling, communications and delays. However, we have found additional evidence relating to the Chronology and some of our interpretations of the evidence on that issue therefore differ, to some extent, from the PSA. The following summary of events is adapted from the PSA report.

Baby A

5.4 Baby A was born on 27 October 2008 at Furness General Hospital. He died on 5 November 2008. Baby A's parents, Mr and Mrs A had concerns about the treatment that they and baby A were given. They brought their concerns to the attention of the hospital management and, ultimately, the NMC.

Further incidents and the Kirkup report

5.5 This was one of a number of cases at this hospital that gave rise to concerns. The Kirkup report ultimately identified at least 20 cases where there were major or significant failures of care, 13 of which may have had different outcomes if care had been handled differently. The cases related to three maternal deaths, ten stillbirths and six neonatal deaths occurring between 2004 and 2012. The report found *"a series of failures at almost every level - from the maternity unit to those responsible for regulating and monitoring the Trust"*.

The NMC's role

5.6 These incidents in turn led to a series of fitness to practise cases brought by the NMC against Morecambe Bay midwives - a total of 64 cases against 30 individuals were ultimately opened. In this report, we concentrate on two sets of cases: those relating to Midwives 1 and 2 which concerned the antenatal care of Baby A; and those relating to Midwives 3, 4, 5 and 6 which related to his post-natal care.

5.7 The NMC regulates nurses and midwives in England, Wales, Scotland and Northern Ireland. It sets standards of education, training, conduct and performance to ensure that nurses and midwives deliver high quality healthcare. The NMC maintains a register of nurses and midwives allowed to practise in the UK and therefore its primary role in this context is to determine whether particular midwives are fit to be on the register and to practise.

5.8 The PSA report noted that:

"The Chief Executive of the NMC 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 [Furness General Hospital]."

The NMC's processes

5.9 We note that the NMC's processes for managing complaints and concerns about midwives have changed substantially from 2009 when these events began. The PSA believes now that the NMC's way of dealing with these issues has "*improved considerably*" since that time.

5.10 Complaints and concerns of this sort are dealt with by the Fitness to Practise team within the NMC. The team includes a number of lawyers, but we particularly comment on the role of a senior lawyer who had, in her words, "*overarching ... oversight*" of the Morecambe Bay cases. We refer to her as 'Lawyer A'. The NMC told us that Lawyer A's oversight started at the point that the Morecambe Bay cases were referred for adjudication, i.e. from 2015. They told us that she had no involvement from 2009 to 2014. They also point out that although she had a degree of overall oversight of the cases, she was not the only person responsible for them and that there were others with significant responsibilities for the cases at the same time (e.g. the initial reviewing lawyer, external counsel, etc). Lawyer A reported into the former assistant director for legal services who had overall responsibility for legal case presentation in the fitness to practise directorate.

5.11 Until 2012, most investigations were carried out by external solicitors. In Baby A's case that was initially Capsticks Solicitors, with the role later taken on by Morgan Cole Solicitors. Investigations are now mostly handled in-house. The investigators review documents and take statements from witnesses, as well as getting expert advice where necessary. The output is a report which summarises the results of the investigation including an assessment of whether there is sufficient evidence to prove facts to the required standard. In the past, the report included a recommendation on whether there is a case to answer. The current process is for the investigation report to include the investigator's assessment about whether there is sufficient evidence to give rise to a case to answer in respect of facts, rather than making a recommendation on whether there is a case to answer.

5.12 Until 2016, following its completion, each report was considered by an 'Investigating Committee', which made a final decision on whether there was a case to answer.

5.13 Those with a case to answer were heard by panels of the Conduct and Competence Committee (we refer to this as the 'hearing committee'; it is now known in the NMC as the

'Fitness to Practise Committee'). These are panels of three people with at least one registrant and a lay person. These cases were heard at hearings, which the PSA describes as "*not unlike trials*". At the hearing discussed in this report, both the NMC and midwives were legally represented by barristers (counsel) and evidence was challenged. Mr and Mrs A, who appeared as witnesses, were not represented (the NMC told us that there is no provision within their legislative framework for witnesses to be represented at hearings). The hearing committee took the decision on whether the allegations were proven and, if so, whether they were sufficient to say that the midwife's fitness to practise was impaired. Sanctions available include a caution, suspension or striking-off from the register.

5.14 The PSA report made the following comment (with which we agree):

"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."

The Chronology

5.15 The Chronology was written by Mr A to summarise the main events relating to his son. It consists of three sheets (six sides) of A4 paper. Five of the sides are typed. The sixth side has two photos of Baby A. One of the photos was taken immediately after his birth and is dated 27 October 2008. The other was taken on 10 November 2008 in the chapel of rest.

5.16 Below the photos is Mr A's name and the date - 10 November 2008.

5.17 The document is headed as follows:

"[Baby A] 27/10/08 - 05/11/08

“Chronology of events”

5.18 It begins, “*The following is a history of [Baby A’s] circumstances as seen by us...*”.

The significance of the Chronology

5.19 The Chronology is a near contemporaneous record of events, having been completed five days after Baby A’s death. As we will describe, Mr A first presented the Chronology as evidence in 2009. Under a heading, “*Saturday, 25 October*”, the document says:

“We told the midwife that [Mrs A] was feeling unwell and described the symptoms very clearly”.

5.20 At a fitness to practise hearing, seven years later, counsel for one of the midwives suggested that his evidence was “*unreliable*” on the basis that he had not mentioned the fact that Mrs A was unwell at the time, and had only raised the issue at the inquest in June 2011. This claim was reported by the press at the time, causing Mr and Mrs A considerable distress.

5.21 Outside of the hearing, Mr A pointed out that the Chronology clearly demonstrated that the claim was false. He asked the NMC why the document was not included with the evidence for the case and what they had done with it. At the time, the NMC did not describe accurately to Mr and Mrs A what it had done with the Chronology, and why.

‘Baby A’s story’

5.22 Mr A also produced another document, entitled “[Baby A’s] story”. This is a PowerPoint presentation of 31 slides. The first slide shows a picture of Baby A and the second slide includes the following:

“The sequence of events described is based on our chronology of events and the external investigation report...”

"The presentation seeks to tell [Baby A's] story in full in the hope that the same tragedy suffered by our family, can never be allowed to befall another child."

5.23 Baby A's story goes on to tell the events in chronological order, with headings such as *"the pregnancy"* and *"the days before the birth"*. The next slide is headed *"pre-labour"* and includes the following:

"At the maternity unit, we told the midwife that [Mrs A] was feeling unwell and described the symptoms.

"We were very anxious about infection and we discussed these concerns with the midwife."

5.24 The presentation goes on to describe Baby A's birth, treatment and subsequently his death. It includes photos of Baby A and viscerally describes the grief after his death. It is powerful and moving. All those we spoke to told us of the big impact that it made on them.

5.25 Baby A's story is undated.

5.26 Mr A also wrote a book entitled "[Baby A's] story".

Comment

Baby A's story is an incredibly powerful and emotional document which has an enormous impact on its readers.

It is also important to note, however, that it is also "a chronology" - i.e. it tells a sequence of events in chronological order.

Baby A's story describes the same events as 'the Chronology'. It makes the same reference to Mr A's having told "the midwife" about Mrs A feeling unwell. The main difference of significance is that Baby A's story is undated, while the Chronology is dated.

As we will discuss, we believe that many of the contradictions that we discuss in this report (and were identified by the PSA) can be explained if people who mentioned having seen “the Chronology” were in fact referring to Baby A’s story.

6. Referral to the NMC and Capsticks (2009 - 2010)

Referral

6.1 Mr A first raised issues about the performance of a number of midwives with the NMC in February 2009. In July 2009, cases relating to four midwives (referred to here as midwives 3, 4, 5, and 6) were formally referred to the NMC Investigating Committee. The cases were considered by the Investigating Committee on 9 September 2009, and on 17 September the midwives and Mr A were written to on behalf of the committee chair to say that the case would be investigated further.

6.2 At this time, Mr A provided the NMC with evidence relating to the cases. An email dated 22 July 2009 from Mr A to the NMC refers to him having produced "*a presentation that gives a summary of [Baby A's] short life*".

6.3 On 18 September the NMC passed the cases of the four midwives to Capsticks. Capsticks is a firm of solicitors that specialises in work in the public sector, and NHS in particular. At the time it had a contract with the NMC for providing services to support this type of case. Mr A made a statement to Capsticks in October 2009.

The process

6.4 We interviewed a current partner at Capsticks to find out about the process followed at the time. He told us that each case had three main people working on it:

- Partner - who oversaw the case
- Case-holder - who managed the case
- Paralegal - who carried out much of the day to day work, such as taking statements and preparing the file.

6.5 When witnesses are interviewed, statements are taken. Statements reflect the accounts that witnesses give of an event, presented in a way that will assist the decision maker (in this case the Conduct and Competence Committee). They are not intended to be transcripts of what interviewees have said. This process continues, although it is now often done by the NMC in-house.

6.6 In making a statement, witnesses may refer to documents. Such documents can then be attached to the statement. These are known as 'exhibits'.

6.7 At the time, the practise (on occasion, though not routinely) was for early versions of a case file (on paper in ring binders) to be sent to the NMC before it was complete. Such versions of the file might include draft (unsigned) witness statements. Updates would then be sent to the NMC to be inserted in the file. The aim of this was to speed up the process. This process is no longer followed.

Comment

The process followed at this time was unusual. Although motivated by a desire to act as swiftly as possible, the idea of sending incomplete files that were then updated was undesirable as it meant that there was a risk that there would be no single agreed version of the file. As we will discuss below, in this case it meant that the file held by the NMC was ultimately not the same as that held by Capsticks.

Mr A's statement

6.8 Capsticks gave us a number of versions of Mr A's October 2009 statement from their files:

- 12 October 2009¹ - unsigned
- 10 May 2010, 18:45 - unsigned
- 10 May 2010, 18:52 - unsigned
- 28 May 2010 - signed and dated by Mr A.

6.9 All four versions focus on care given after Baby A's birth (as this was the focus of these cases). However, the statement evolves through these different versions. We explain that process of evolution below.

¹ The dates shown for the first three versions of the statement are the times that they were created on Capsticks' system. They may have been amended after this date.

6.10 On 30 September 2009 Mr A wrote to the paralegal at Capsticks saying that *“I can confirm that we will assist you in any way possible regarding the witness statement you have requested”*. The email continues:

“Shortly after [Baby A’s] death, my wife and I carefully documented what happened to [Baby A] at FGH. I wonder if you already have our chronology or any of the other information I have provided to the NMC?”.

6.11 Mr A emailed the paralegal again on 5 October at 17:23. The email was entitled *“{Baby A}’s Story - version3.ppt”*. Mr A attached a copy of Baby A’s story and wrote:

“I have attached a presentation that I have prepared that sets out [Baby A’s] story in full. As you are now involved with a specific investigation relating to [Baby A’s] death, please review this presentation as it does set out a truthful account of what happened and will help you understand our case”.

6.12 The following day (6 October 2009) at 10:51 the paralegal emailed Mr A saying:

“Thank you for your email and the additional information. I have already have [sic] a chance to read a hard copy of your chronology, which I received from the NMC...”

Comment

Mr A had sent the paralegal a copy of Baby A’s story the previous evening. When the paralegal refers to already having read “your chronology” we believe that it is likely that he was referring to Baby A’s story.

6.13 Mr A and Mrs A were interviewed by the paralegal with regards to midwives 3, 4, 5 on 16 October 2009. After the interviews, the paralegal emailed Mr A (on 23 October 2009) saying that he would be *“in touch in due course with draft statement for you and [Mrs A].”*

6.14 The 12 October version of the statement is shorter than the others - 17 paragraphs across two and a half sides of A4.

6.15 On 23 November 2009 Mr A emailed the paralegal:

"Just a quick email to ask how things are going with your investigation? Have you completed our statements yet?"

6.16 On 24 November 2009 the paralegal replied apologising for the delay in preparing the statements, saying:

"I am still in the process of gathering evidence from elsewhere in this matter and I have postponed completing your statements in case, following my further investigations, I have any additional questions for you."

6.17 On 4 December 2009, Capsticks asked the NMC for an extension to the time needed to complete the case.

6.18 The paralegal emailed Mr A on 15 December 2009, again saying that the statements had not been completed as the investigation was on-going.

6.19 On 6 January 2010, Mr A again asked for an update on when the statements would be ready. The paralegal responded on 8 January again apologising for the delay and saying that he was *"keen to complete my report to the NMC by the Spring"*.

6.20 Mr A emailed the paralegal again on 28 January asking for an update and expressing frustration at the delay and concern that *"our statements, which were taken some months ago, have still not been issued to us"*. The paralegal replied the same day to say that he had recently completed the interviews for his investigation and was now reviewing the evidence to see if he had what he needed to complete the report. He also said that he had resisted producing statements up to now as he wanted to have *"a complete picture of the evidence before doing so"*.

6.21 Mr A chased again on 9 March and 30 March 2010. On 6 April the paralegal emailed to say that the statements should be sent out soon.

6.22 The statements were finally sent on 19 April 2010. On 20 April Mr A responded saying that he intended to make some *"corrections/additions"* and would respond soon.

6.23 Mr A returned the statement on 9 May 2010 with a significant number of additions which provided important additional evidence and substantially increased its length.

6.24 One of the additions related to Mr and Mrs A informing midwives that they felt unwell. The statement sent to Mr A included the following sentence:

“Prior to the birth of [Baby A], both [Mrs A] and I had been tired and unwell with headaches and sore throats...”

6.25 Mr A proposed the addition of the following words (which then appeared in all subsequent versions of the statement):

“This is something my wife and I talked about with staff when we made the first phone call to the maternity ward on Saturday 25th October and something we discussed in detail on each subsequent visit to the maternity ward prior to the birth.”

6.26 The end of the statement referred to [Baby A's] story as an exhibit. Mr A asked which version of Baby A's story Capsticks had and supplied a revised version that he had updated following receipt of the Local Supervising Authority report into Baby A's death. Mr A also wrote:

“I would also include as evidence our original chronology which we submitted to the trust on 14th November 2008, just days after [Baby A] died.”

Comment

As we will discuss later in this report, the evidence that Mr and Mrs A had told staff that they were feeling unwell was important to later cases.

10th May 2010

6.27 The 18:45 version of Mr A's draft statement (dated 10 May 2010) is longer than the previous version at 19 paragraphs and over three and a half pages. It includes other factual additions to the statement, including additional dates and times.

6.28 With regards to exhibits, the 18:45 draft says:

"I attach as exhibit JT1, a copy of a document that I produced which is entitled "[Baby A's] Story" and which contains a chronology of events concerning [Baby A], including those that are described above."

6.29 The next version of the statement is timed at seven minutes later - 18:52. This is identical to the previous version, except for the section on exhibits, which now reads:

"I attach as exhibit JT1, a copy of a document that I produced which is entitled "[Baby A's] Story" and which contains a chronology of events concerning [Baby A], including those which are described above. I also attach as exhibit JT2, a chronology that I produced on 10 November 2008".

6.30 The final, signed version of the statement is dated 28 May 2010. The text includes reference to telling staff about feeling unwell and to both exhibits - JT1 and JT2. There are two cover sheets for exhibits, but both are cover sheets for JT1. JT1 is attached, JT2 is not.

6.31 At the end of witness statements is a cover sheet for exhibits. All the versions discussed here have a cover sheet for JT1, which refers to "the exhibit marked 'JT1' referred to in the witness statement of [Mr A]". The final version of the statement includes a cover page and a copy of '[Baby A's] Story'. It does not, however, include a copy of JT2.

6.32 On 10 May 2010, the paralegal emailed Mr A as follows:

"Thank you for your email. I do not believe I have a copy of the chronology to which you refer. Would you please be able to email me a copy?"

6.33 Mr A replied to Capsticks on 12 May 2010 attaching a copy of the Chronology:

"I wrote this chronology on 10th November 2008 just 5 days after [Baby A] died. It was submitted to the trust on 14th November 2008.

"This is exactly the same document as originally submitted."

6.34 On 13 May, the paralegal emailed Mr A saying that he would send out final copies of the statements for signature shortly. He said that he anticipated the NMC making a decision within approximately three months.

6.35 On 25 May 2010, the paralegal sent out copies of the statements to Mr and Mrs A with the requested amendments made. This version of the statement includes the reference to JT1 and JT2 described above.

6.36 The paralegal asked for the statements to be returned by post and said:

"Please note that I am leaving Capsticks to take up a position at another firm. However, this will not affect the conduct of this matter as my colleague ... will be dealing with the case..."

6.37 Mr A replied on 28 May wishing the paralegal luck in his new job, but was sent an out of office message saying that the paralegal had now left.

6.38 The case-holder at Capsticks confirmed receipt of the statements on 3 June 2010.

Comment

The Chronology was not appended to the original version of Mr A's statement. That original version of the statement was sent to the NMC. After this had been done, and between the time when the final statement was sent to Mr A for signature and he returned it, the paralegal dealing with the case at Capsticks left the organisation.

We do not believe that the NMC ever received a copy of the Chronology (prior to it being emailed by Mr A in 2016, see below).

As we have already noted, the practise of sending incomplete files was not a good one and invited this sort of error. In this case, the NMC's file is dated 7 May, but includes a statement which was signed and dated on 28 May. If this practise was still followed it would raise many concerns because it introduces a lack of clarity in the process. We were assured that the process is now electronic and that the standard practice is now to return reports only when signed witness statements have been received, so this issue could not arise again.

Nevertheless, ensuring proper filing and recording of documents is an important part of the role of external solicitors and the failure to keep track of documents in this case is disappointing.

The Capsticks report

6.39 The Capsticks report is dated 7 May 2010. However, the cover letter to the report sent to the NMC is dated 11 May. Capsticks told us that their electronic time recording system shows that some work was done on the file on 10 May and 11 May.

6.40 The report recommended that there was no case to answer against the midwives.

Comment

It is possible that Capsticks completed its report and made a determination on whether there was a case to answer before receiving a final version of Mr A's statement and therefore before they had all the relevant evidence. If so, this clearly would have been unsatisfactory. Certainly, they gave very little time to considering the additional evidence that he provided.

Capsticks state that, in the period between interview with Mr A on 16 October 2009 and 19 April 2010, they wrote to numerous people to gather documentary evidence and spoke to five witnesses in the case. Their system records 25 hours having been spent drafting the witness statements. Capsticks state that it is common practice when gathering information for an investigation to hold off finalising statements in case additional material comes to light which raises new matters to be put to witnesses.

Despite this work, when the final draft of his witness statement was sent to Mr A, he clearly had significant concerns about it, as demonstrated by the fact that he made a large number of additions - essentially doubling its size. It therefore seems incongruous that, having spent six months developing the statement, the additions made by Mr A were accepted and included in the final report to the NMC without a further period of reflection and checking. The paralegal handling the case left Capsticks shortly after the submission of the report and evidence to the NMC. This suggests the likelihood that he was working towards getting the report to the NMC prior to his departure, leading to a degree of haste in the final compilation of the report and its supporting submissions which should have been apparent to more senior staff in Capsticks. There is no evidence that Mr A's chronology was included in the bundle sent to the NMC with the investigation report. Errors of this kind are more likely when work is completed 'in a hurry' rather than in a more considered fashion. We, therefore, consider that this aspect of Capsticks' process was also unsatisfactory.

7. The inquest and Morgan Cole¹ (2010 - 2013)

7.1 Capsticks completed its work at the end of May 2010. In June the cases were put on hold, pending the inquest. The inquest was held in June 2011. Following the inquest, the hold on the cases was removed, but re-imposed almost immediately after the announcement of a police investigation (despite objections from Mr A that this was unnecessary). The police investigation continued until December 2014. As a consequence, little happened in these cases in the NMC in the three and a half years from June 2011 to December 2014. It should also be noted that in September 2013 the Kirkup investigation was established.

Comment

It is not for us to comment on whether these delays were necessary - although we note the PSA's comments that it is not clear that they were. However, we believe that the length of this delay is important to understanding what subsequently happened with the Chronology. Over such a long time period it would have been difficult for individuals to remember the details of the case and there were changes in staff involved in the case which further reduced organisational memory.

7.2 An exception to this general lack of activity was that, in July 2012, a second legal firm, Morgan Cole, was asked to re-investigate the cases of midwives 3, 4, 5 and 6. Morgan Cole had been awarded the external investigation contract, taking over from Capsticks. As part of the handover process, Morgan Cole were asked to re-open a number of cases. This work was carried out in the second half of 2012, before the hold was placed on the cases for the police investigation.

7.3 A letter sent by Morgan Cole to Mr A after it had completed most of its work (dated 17 October 2014) set out what the firm had been asked to do. Morgan Cole wrote:

"It may be helpful to set out the process that was followed when we were instructed to conduct fitness to practise investigations into a number of midwives and nurses.

¹ Morgan Cole merged with another legal firm to become Blake Morgan in 2014.

We were instructed to give investigate [sic] the clinical care provided and to investigate whether there was any evidence of collusion.

“We reviewed evidence which had already been provided from a number of previous investigations including the NMC’s earlier fitness to practise investigation, the criminal investigation, and the Inquest. We also considered previously published reports including the recent Parliamentary and Health Ombudsman report. In addition to reviewing evidence which had already been gathered, we also conducted a number of witness interviews, obtained disclosure of documentation from University Hospitals of Morecambe Bay NHS Trust (“the Trust”) and we instructed an independent expert to comment on the standard of clinical care.”

Comment

Morgan Cole refer to reviewing the previous evidence that the NMC had collected. We assume that this includes the work done by Capsticks. Nevertheless, this was one strand amongst a number of other sources of evidence, notably those collected for the criminal investigation and the inquest. While it is, therefore, unsurprising that Morgan Cole did not comment on a missing exhibit to Mr A’s 2010 statement, this does represent another missed opportunity to identify that the chronology was not on the case file.

7.4 As part of its work, Morgan Cole interviewed Mr A and took statements from him in relation to a number of cases. We were provided with one of these statements as an example. It is signed by Mr A and is dated 10 October 2012. It is six and a half A4 sides long.

7.5 The statement is described as being in relation to a single case - that of midwife 3. It says:

“This statement is made in relation to a specific incident that arose as part of a number of concerns following the birth of my son. The description of events relating to [Baby A’s] birth is a summary of events and not a detailed account...”

7.6 The statement deals with issues after Baby A's birth and some subsequent events in 2011 and 2012. It has a total of nine exhibits. None of them is either Baby A's story or the Chronology. Morgan Cole told us that this was because the issue being investigated in this instance was alleged collusion between the midwives after the event, rather than Baby A's care.

7.7 We asked Lawyer A whether she referred back to the Capsticks files or only looked at the work done by Morgan Cole when she became involved in the case. She told us:

"I never really saw the original [Capsticks] file. The first time I ever laid eyes on it was the time of the PSA review, and even then, I didn't really do much with them. I knew they were around, but I had never seen the original ones. They were not retained, it was only the Morgan Cole files that we worked on. We never worked on the Capsticks one."

Comment

One of the questions that most puzzled people we spoke to at the NMC was how the fact that the Chronology was not attached to Mr A's statement could have been missed by so many people as they reviewed the file.

We do not seek to excuse the mistakes that were made, but it is fair to point out that prior to the preparations for the 2016 hearing for midwives 1 and 2 (discussed in section 8 below), only a small number of people would have reviewed a file with Mr A's original statement in it. Almost immediately after the completion of the file, the case was put on hold. By the time that the hold was finally lifted, several years had passed and a new file had been produced.

8. Midwives 1 and 2 and the hearing (2014 - March 2016)

8.1 The investigation into midwives 3, 4, 5 and 6 concluded in July 2014. The cases were considered by the Investigating Committee in November 2014. The Investigating Committee decided in January 2015 that there was no case to answer in one of the cases (number 5). The Investigating Committee decided that the other three cases should proceed to fitness to practise hearings by the Conduct and Competence Committee (the 'hearing committee').

8.2 In February 2014 cases were opened into two further midwives - 1 and 2. These midwives were also involved in the care of Mrs A, but in these cases their involvement only related to a time before Baby A was born.

8.3 On 31 October 2014 the then director of fitness to practise wrote to Mr A to update him on cases 3, 4, 5 and 6. Mr A was also written to about the outcome of the Investigating Committee in early November. Mr A was concerned about the decision to drop the case against midwife 5. He replied to the former director of fitness to practise on 16 November 2014. In his letter he dealt with a number of points of evidence. These included the issue of whether he had told the midwives about feeling unwell, as this was being disputed by the midwives in question:

"On the matter of whether or not my wife and I discussed feeling poorly with staff on the initial visits to FGH after [Mrs A's] waters broke, I can tell you again very clearly that we did. My wife and I gave clear evidence under oath at the inquest relating to this. Evidence that the coroner accepted ... my wife and I would never seek to exaggerate or make up any aspect of the circumstances relating to our sons short life and death. We are certain about what we discussed with staff.

"What exactly do you need to refer for further investigation relating to this? Are the several statements we have made consistently since [Baby A]'s death not enough? These include the chronology of events written and submitted just days after [Baby A] died and you have the transcript of the evidence we gave under oath to the inquest. Why yet more delay?"

8.4 The hearings in cases 3, 4 and 6 ultimately took place in May 2016. The Chronology did not arise at those hearings.

8.5 In late 2014 the cases relating to midwives 1 and 2 were considered by the Investigating Committee. The Committee decided that the cases should proceed to a fitness to practise hearing, although Morgan Cole had concluded that there was no case to answer.

8.6 Following the Investigating Committee's decision, the NMC reviewed the cases again in order to ensure that they had the evidence needed for the hearing. Lawyer A told us that in high profile cases such as these, the NMC appointed external counsel (a barrister) to represent them (we refer to her in this report as 'counsel to the NMC'). The papers were therefore sent to the counsel for the NMC. On 22 November 2015 she wrote back to another lawyer who was working on the case (but was not closely involved in drafting the subsequent correspondence), with Lawyer A copied in. In her letter (which was provided to us by Lawyer A), external counsel noted that "*There are a few missing documents in the bundles that have been forwarded to me*". Her note included the following:

"FATHER A, I do not have a copy of his exhibit JT/2, the chronology. I do not actually require it but I would be grateful for a copy in case the registrants wish to see it"

8.7 We have not seen any evidence of an NMC response to this.

Comment

This represents another missed opportunity. The issue of the Chronology had again been raised with the NMC, but again the response appears to have been inadequate.

8.8 Following further consideration of the case papers it was decided that additional statements were needed from Mr and Mrs A because these cases involved a dispute of fact. Lawyer A distinguished this case from those of midwives 3, 4, 5 and 6 which were concerned with expert evidence - whether the midwives did the right thing in the circumstances. In contrast, she told us about cases 1 and 2:

"They are about a dispute of fact and what this dispute of fact is, is that [Mr and Mrs A] both say they told [Midwives 1 and 2] that [Mrs A] was unwell suffering from an infection and had a sore throat and various other things to do with being

specifically unwell. [Midwives 1 and 2] said no, they didn't. That's the dispute of fact...

"It was identified that we needed to take a further statement to go into some detail about what [Mr and Mrs A] said because their previous statements had been focussed on [Midwives 3, 4, 5, 6] and whoever took care of [Baby A] after birth, so the statements were very cursory about what happened before [Baby A] was born and didn't really cover that issue, so we needed a further statement.

8.9 Mr A's third statement is dated 15 February 2016. Lawyer A told us that there were no exhibits to this statement. She told us:

"I went up with the [NMC] paralegal that took the statement. I was not there when they took the statement. I cannot really answer whether they discussed exhibits. I am assuming not because we thought we already had them on the old statement. That would be my assumption. I did go up. I was there when that statement was taken, but what I did was to talk to Mrs A when Mr A was giving his statement, and vice versa. So I wasn't there at the statement taking. They went into a different room and did that, but the head of paralegals, as I think he was then, I would have assumed probably did not ask about exhibits because we thought we had them.

8.10 We asked the Lawyer A whether this statement was intended to be supplemental to the previous statement that had been taken. She told us:

"Yes. The old statement that Capsticks originally took was very brief on the events as they related to [midwives 1 and 2], so this was the antenatal care. It went into a great deal of detail, and we did use it, for [midwives 3, 4 and 6] which were the later cases. So they were to do with the care of [Baby A] after birth, and most of those original statements were taken from [Mr A]. There was one from [Mrs A] I think, but it was very brief as well, but the one that [Mr A] gave focused much more on the events after the birth, and that is because, to be fair to Capsticks on that one, the referral that we originally had was about the care that [Baby A] received after birth. It didn't touch necessarily on what [midwives 1 and 2] had done.

"We were not investigating them when the referral first came in, so it focused very much on those events, and it was what we needed for that. I mentioned that this

case was originally was a no case to answer, so when this was put through as a case to answer, looking back at the original statement with ... the lawyer who reviewed it first once it had been put through, took the view that it just didn't really go into the detail of what [Mrs and Mr A] had told [midwives 1 and 2], and given that we had the expert saying that is the key, we needed to ask them specifically about what they told, and who they told."

8.11 Mr A's 2016 statement is three and a half sides long and refers specifically to the hearings relating to midwives 1 and 2. It says:

"I remember crystal clear, telling the midwives that we had been feeling poorly with headaches and sore throats and that our daughter had been sent home from nursery. They said 'not to worry it was probably a virus as there are lots going round at the moment'."

8.12 It was this 2016 statement which was ultimately presented to the hearing.

8.13 There was a pre-hearing for the case of midwives 1 and 2 in October 2015 and the hearing was held in March 2016.

At the hearing

8.14 Mr A gave evidence on the first day of the fitness to practise hearing. At the beginning of his evidence he said that his understanding was that he could refer to "my wife" and the name of his child, rather than using anonymised terms. He pointed out that everyone knew who Baby A was, and that it would be easier for him to refer to "my wife", rather than "Patient C". The transcript records the following exchange:

"THE CHAIRMAN: On the one hand we want you to do what is comfortable and, on the other hand, out of respect for Baby A and your wife, we would prefer that you use the terms "Baby A" and "Patient C". If you forget do not worry, but if you can adopt the anonymised terms.

"THE WITNESS: I think I feel quite strongly that this is about [name given] and, you know, he's a baby that died.

"THE CHAIRMAN: Very well. You must do what is comfortable."

Comment

It is easy to see why Mr A found the Panel's approach to be inappropriate and insensitive.

8.15 Mr A was cross-examined by counsel for midwife 2, which concluded as follows:

Q. In terms of what advice you were given before leaving, you were perfectly happy, were you not, with the management plan that you had been advised about in terms of taking your temperature and the like and contacting the hospital in the event of any significant change. Would that be fair?

A. Yes. There's only one issue that's in contention and that's whether we had a detailed conversation about my wife and myself feeling poorly. That's the discrepancy. For this particular piece of Baby A's story, you know, Baby A had lots of missed opportunities as to what happened to him. I've always been clear these two ladies that we saw on the Saturday night were thorough, they reassured us. I had no complaints. The only issue for me is this discrepancy about the conversation we had. I'm very sorry that that's arisen, but I'm here to tell the truth. I'm absolutely 100% clear about that conversation, as is my wife, and that's the issue that I will swear or take any kind of lie detector test that that's the truth. That's what hasn't been reported accurately.

Q. Your first witness statement in these proceedings was made in May 2010, was it not?

A. Possibly.

Q. The second witness statement you have made, the one that was read out, is I think dated either 13 or 15 February 2016.

A. Yes, because the NMC process has been pretty agonising and we've had to make, yes, different statements at different times.

Q. Thank you"

8.16 On the third day of the hearing, Mrs A gave evidence. Counsel for both midwives asked her in some detail about whether she had previously given evidence about feeling poorly and compared the statements that she made to Capsticks, the inquest and her evidence to that hearing.

8.17 On the third day of the hearing, following the evidence against the midwives, counsel for both midwives made a submission of 'no case to answer'. This is a common procedure at this stage of hearings and allows counsel for the midwives to argue that the evidence that has been presented is insufficient to allow the panel to conclude that the case should proceed to a finding against the midwife. During his submission, counsel for midwife 2 referred to what is known as the '*Galbraith test*' for making a decision on when to halt a case at this stage. That includes where there is a concern that the evidence is "*inherently unreliable or tenuous*". He went on to say that

"It is plain that the documented details of treatment or assessments carried out on [Mrs A] contained within our Exhibit 1 do not support at all the contention that unwellness, if that is the proper word to use, was raised, mentioned, far less established, at any of these appointments..."

"What we have here, I submit, is a background contained within documentation which simply does not support a finding that, first, the patient was unwell at any stage and, second, had at any point mentioned that she had been unwell."

8.18 On the specific point of the reliability of evidence, he went on to say:

"The very fact that the first and only mention of being poorly, having headaches and sore throats appears to have arisen for the first time, as I say, at the inquest hearing in June, I think it was, of 2011, and both the parents have made statements which are before you, and the dates are shown at the bottom, which gives rise to, in my submission, a proper inference that there is scope, at the very least, for that recollection to be unreliable."

8.19 We asked counsel for the NMC at the hearing whether it would have been possible for her to object to the submission made by the representative of the midwife. She told us that this would have been difficult. Representatives at hearings do not generally interrupt or object to submissions made by other representatives and would only do so in the most extreme circumstances. The focus of counsel for the NMC was also on making their case on behalf of their client, rather than commenting on the accuracy of statements made by others. The NMC's counsel suggested that this sort of point might best be made by the legal assessor to the panel.

8.20 The reporting of these events was that both Mr A and Mrs A had been described at the hearing as being '*unreliable witnesses*'. This was reported in the media, for example, "*Parents recollections branded 'unreliable' at midwives hearing*". ITV News, 10 March 2016.

8.21 Lawyer A told us that she had a lot of sympathy for Mr A about the way he was treated. She told us that she "*felt terrible*" about the way the issue of anonymisation was handled, "*I can't think of anything worse and I have said from the get-go that was appalling*".

Comment

Counsel have a professional responsibility to represent their client's interest fearlessly. Nevertheless, criticising the evidence of bereaved families should only be done if it is strictly necessary and then with extreme care and respect.

It is possible that counsel for midwife 2 intended only to refer to Mrs A's evidence, but that is not at all clear from the words used. It is not at all surprising that his words were interpreted to be referring to both Mr and Mrs A.

The assertion that Mr A's first mention of feeling poorly was at the inquest is entirely and demonstrably false. Mr A consistently made clear that he and Mrs A had been feeling unwell, notably in the Chronology and in his signed statement to Capsticks.

It is clearly not appropriate to draw general conclusions about the proceedings in this kind of hearing on the basis of one single instance. Nonetheless, for the reasons discussed here, if this is a problem that is likely to recur, action should be taken to

remind participants in hearings of the importance of treating bereaved families with respect.

Furthermore, the NMC does not appear to have been well prepared on this point. This was clearly a key point in dispute at the hearing. Finding any inconsistencies in the evidence of Mr and Mrs A over the previous eight years was an obvious line of attack for counsel for the midwives to make. Mr A's consistency and clarity on this point over a number of years, which included recording it in the Chronology written days after Baby A's death in 2008, his specific request that the point be added to his statement to Capsticks in 2010 and his email to the NMC in 2014 emphasising the point, would all have been significant points of rebuttal if those representing the NMC at the hearing had been aware of them.

More generally this incident reflects a system that is set up with a particular aim - to determine the fitness to practise of a midwife - rather than to investigate into the death of a loved one. However, other comments by the chair of the panel also indicate a lack of sensitivity to the position of bereaved parents.

Ultimately the responsibility for ensuring that bereaved families are treated appropriately is one for the chair of the panel.

R1 Recommendation

The Nursing & Midwifery Council should ensure that Panel chairs are fully briefed about the importance of showing respect to bereaved relatives, perhaps by using this example as a case study.

Response to the press reports

8.22 After the issue appeared in the press during the hearing, Mr A contacted Lawyer A to point out that the press reports were incorrect and that he had raised the issue of himself and his wife feeling ill on a number of occasions. He also pointed out that the Chronology, which he had written a few days after Baby A's death, was clear on this point. He emailed the Chronology to Lawyer A as proof of this. His email attaching the Chronology was sent

at 18:01 on 10 March 2016. It says " *this document was written on 14th November 2008 and submitted to the trust that week*". He also wrote to the then chief executive (with Lawyer A copied in) at 18:29 the same day. In that email he wrote:

"I attach the chronology that I produced (I made the notes when [Baby A] was still alive) and which I submitted with my father to the trust in November 2008, just a few weeks after [Baby A's] death".

8.23 Lawyer A told us that this was the first time that she had seen the Chronology. Her recollection was as follows:

"I think where it came from is that after the NMC finishes its case, the defence can make an application for 'no case to answer'. There were two defence reps and one of them, for [midwife 2], from memory, but I could be wrong about that, made a comment that the first time that [Mr A] had mentioned [midwives 1 and 2's] involvement or telling [midwives 1 and 2] that [Mrs A] was unwell, was at the inquest, and that he had never mentioned it before then.

"The press picked up on that, so that one comment was widely reported, which was a submission, which was incorrect anyway. It was totally incorrect, but the press picked up on that, and that is when I remember [Mr A] saying 'What about this chronology?'"

8.24 Lawyer A told us that she then looked for the Chronology on the NMC's system, but could not find it. She said that Mr A then emailed it to her, so that the first time that she saw the Chronology was while the hearing was going on. She said that counsel was sitting next to her when she received the Chronology and they considered it together. They discussed whether the Chronology should be put in as evidence to the hearing but decided not to do so.

8.25 Lawyer A gave us a number of reasons for not including the Chronology as evidence. The first reason related to when it was written. She told us:

"It is not contemporaneous in the way that medical records that the midwives were making at the time were."

Comment

It is true to say that the Chronology is not a contemporaneous record in the strict legal sense, i.e. that it was written as events were happening in the way that patient notes are. Nevertheless, it was written shortly after the events took place, which means that it is a lot more valuable as evidence than recollections made well after the event.

8.26 The next reason that Lawyer A gave for not using the Chronology was that it did not resolve the issue that had arisen as to whether Mr and Mrs A had told a single midwife or more than one midwife about feeling unwell. She went on to tell us:

“Also, I took the view that it was patently obvious that the submission from counsel was wrong because we knew [Mr A] had given an account of this before. His first statement was in 2008, and that was already known to everyone, so if showing a document that says he actually gave that account ages ago wasn’t adding anything to the stuff that the panel already knew,

“Those were all the reasons for not doing it, and I took that decision. That was 100 per cent my decision once I saw it because [Mr A] emailed it directly to me, and that was the point at which I thought I am going to look at this, and I discussed it very briefly with external counsel. She agreed that really there was not any value in putting this in at this stage without opening a whole new can of worms.”

8.27 With regards to the media reporting, Lawyer A went on to say that the media:

“... picked up on that one phrase without talking about the response that was given, and actually that was just nonsensical because we all knew that [Mr A] had given that account long before. He first signed the statement for us in 2008. Forget this document. So we all knew that was rubbish. The Coroner’s took place in 2010/2011 so we all knew that was nonsense, but they picked up on that one thing.”

8.28 Given the high-profile status of the case, the former director of fitness to practise took a direct interest in the case. She told us that she first heard about the Chronology when she was at the hearing centre at the time of the hearing:

“From memory, the first time I became aware of a chronology being any sort of thing was during the hearing, I think it was during the hearing. I was at Stratford, which is one of our hearings centres, I was there working for the day, I wasn’t there specifically because the case was on. I became aware, I think, of an issue around the chronology, and I think ... that Mr [A] had raised the issue as to why his chronology hadn’t been put before the hearing, and I think I’m right in saying that he was asked a question about whether or not he’d ever made a note of what he had said about these particular midwives, because these are the antenatal midwives, aren’t they? [Confirmed]

“He had made reference to the fact - “yes, I did, I made a note, I made a contemporaneous or near contemporaneous note - a chronology” ...

“I wasn’t in the hearing. I don’t know, but I think there was kind of ‘oh well, what chronology?’. I think that’s when I first became involved. I can only think that the day I knew about this must have been the subsequent day, because [Lawyer A] spoke to him over the telephone in the Stratford centre...

“In any event, he was very cross, he felt that the case which subsequently wasn’t proved, a reason for that was because we hadn’t put the chronology forward. At the time I spoke to him, via a speakerphone conversation - [Lawyer A] was there, and myself - I remember asking the question, what’s this chronology, understanding that the chronology didn’t, in our view, in the collective legal view, have any evidential value.”

8.29 Mr A takes a different view. He told us that he thinks that the Chronology does in fact have evidential value and that the reasons the NMC gave for not presenting it as evidence are spurious.

Comment

The NMC’s immediate response during the hearing focussed on whether it would support then NMC’s case to submit the Chronology as evidence. This, together with

the question of exactly when they had considered whether the Chronology should have been used, became the central issues for the NMC.

With hindsight, it can be seen that these questions were not those raised by Mr A and therefore missed the point. Mr A's integrity and reliability had been attacked in the media. It was clear that the attack was unfounded. The Chronology was evidence that demonstrated that this was unfounded, but it was only one of a number of pieces of evidence. It would have been better in terms of handling Mr A's understandable concerns about his treatment by the media if the NMC had made clear that Mr A's evidence was consistent on this point, rather than focussing on when they had received the Chronology and its evidential value.

8.30 Mr A wrote to Lawyer A several times the following day (11 March 2016). He asked her to *"confirm urgently that the NMC already had this document [the Chronology] and were aware of it"*. He repeated that the Chronology was *"made from notes when [Baby A] was still alive"*. In another email later in the day he asked that she *"confirm that that panel have been made aware and have a copy of the chronology document I emailed you which was written whilst [Baby A] was still alive and submitted to the trust in November 2008"*.

8.31 Mr A also raised the issue of the Chronology with the then chief executive of the NMC. He spoke to her on the day that the reports came out (10 March 2016) and on a number of occasions afterwards. He also wrote to her on 10 March, with a link to the ITV news report. He pointed out how distressing the report was and asked how it was possible for untrue information of this sort to be reported. He attached the Chronology, saying that it *"clearly details the conversations we had with staff"*. The email concluded, *"this is an awful process to subject any family to"*.

8.32 The then chief executive forwarded the email to Lawyer A and said:

"As you know, [Mr A] asked me if I could ring him urgently last night, which I did.

"[Mr A] was very distressed and he said that his wife and his father were, too. He feels very angry and upset that a 'slandorous' comment has been made as outlined in his email below, and you will see that he has just emailed you asking to attend

the hearing today to correct this inaccuracy. I would advise you to ring [Mr A] as a matter of urgency."

Comment

Mr A's view is that as he had discussed the Chronology with senior management within the NMC they must have understood its importance and known that they didn't have it before the hearing. However, we believe that it was more likely that senior management focused on the wider issues such as how Mr A's evidence had come to be attacked so unfairly in the hearing.

9. After the hearing (March 2016 onwards)

9.1 The NMC wrote a number of letters in response to issues that arose in the hearing:

- First letter to Mr A (31 March 2016), signed by former NMC chief executive
- Second letter to Mr A (20 April 2016), also signed by former NMC chief executive
- Letter to PSA (20 May 2016), signed by the former director of fitness to practise
- Letter to Secretary of State for Health (23 June 2016), signed by former chief executive.

9.2 We consider the process of the drafting of these letters below.

The letters to Mr A

9.3 Following the hearing, Mr A wrote to the NMC (12 March 2016) raising the issue of the Chronology, among other matters.

9.4 The former chief executive of the NMC replied to Mr A on 31 March 2016. The letter covered a number of aspects of the hearing, but included the following paragraph:

"In relation to the chronology which you have provided to us, I can confirm that this was not placed before the panel. It was part of the case papers provided to our case presenter but not relied upon in the presentation of the case".

9.5 The former chief executive told us that she was clear that this meant that the NMC had the Chronology before the hearing. She told us:

"I was bemused when I saw the [PSA] report that so much of the report was focused on a document which, at the time my understanding, based on these letters, was that we had it, we considered it, and it wasn't part of the case. So when I got the draft [PSA] report and then I saw the pages of suggestion, implication, that the NMC had not been totally up front about the chronology, came as a huge surprise to me."

9.6 We reviewed internal NMC email exchanges to understand the drafting process for the letters. The emails show that Lawyer A wrote a briefing for the former director of fitness to practise on 14 March in preparation for the reply to Mr A. In it, Lawyer A says, *"we did have the chronology as an exhibit for the cases of [midwives 3, 4 and 6] however there was little reason to rely upon it the hearing [sic]"*.

9.7 We asked Lawyer A why she wrote this email to the former director of fitness to practise. She told us:

"I think she [the former director of fitness to practise] wanted to understand why we didn't use the chronology, basically... she wanted a written record of why that was and whether it was - that was the main thrust of it, but I also think she wanted to know what exactly is this document. I said, "it was an exhibit".

"Q. But it wasn't.

"A. No, but that is where we are getting crossed paths and I have tried to be as clear as I can. Yes, it was missing, but it wasn't missing in the sense that nobody referred to it anywhere. It should have been an exhibit. It was referred to in his statement as 'JT2', so the presumption is, if you have a signed witness statement the accompanying exhibits are in your possession.

As it turns out, it wasn't, but I didn't know that then.

Q. Why didn't you check?

A. I didn't feel that I needed to. This is all very good with hindsight, but you don't normally get to a hearing with external counsel, who has already raised it as a point, with something still missing and nobody then says anything from it.

"Defence never raised it, and, in fact, if you go to counsel's note that I gave you, she says, "the registrants may want to see it." Nobody then raises it as a missing exhibit. Nobody says it is missing. External counsel doesn't come and say, "you never gave me that exhibit." [The NMC lawyer working on the case] doesn't say to me, "I can't find that exhibit." The case officer doesn't say, "this is missing", so

your assumption is, if you have a witness statement at a hearing the exhibits are there. They might not have been relied upon, but they are there. Then that is an assumption you make and it is an assumption. It is a wrong assumption, but it is an assumption.

"I wouldn't have checked because there was, at that stage, no real reason in my mind to think that it would be missing."

9.8 Later on the same day (14 March) Lawyer A wrote "a more formal though in no way final draft of the response to Mr [A]". The draft says:

"We can confirm that the chronology which you referred to was not placed before the Panel. The NMC were aware of the document as it is an exhibit in some of the other cases which have been referred to us but it was not an exhibit in the cases of [Nurse 1 Nurse and 2]."

9.9 On 18 March the former director of fitness to practise wrote to Lawyer A referring to Mr A's request "to see the list of material that our counsel had been given". Lawyer A replied on the same day saying, "I have attached the list of documents that we gave to counsel". This list erroneously included the Chronology.

9.10 Over the next two weeks, work on the letter continued. On 1 April 2016, the head of the chief executive's private office wrote to Lawyer A to say:

"Further to our conversation earlier, just a quick follow up to say thanks for taking the time to look over and discuss the final draft of the letter to [Mr A] and confirming that you are happy with the content."

9.11 The final letter was similar to that originally drafted by Lawyer A, particularly with regards to the text on the Chronology.

9.12 Mr A replied to this letter on 4 April and followed it up with emails on 11 and 15 April. The NMC subsequently replied on 20 April 2016. With regards to the Chronology, the 20 April letter, which also came from the former NMC chief executive, said:

"I note that you are not satisfied with my previous explanation as to why we did not rely on the chronology document. However, I can only re-iterate what I said in my letter of 31 March 2016 that, in our view, presenting this document as part of the cases against [Midwives 1 and 2] would not have added positively to the evidence already before the panel.

Comment

We agree with the former chief executive's interpretation of the meaning of these letters. They strongly imply (though do not explicitly state) that the NMC had the Chronology before the hearing, presented it to counsel and a decision was made not to use it.

We believe this to be incorrect. We do not believe that the NMC had a copy of the Chronology before the hearing, for the reasons set out earlier in the report. This is supported by a number of facts: no-one involved in the case recalls having seen the Chronology before the hearing; it is not included in the papers provided to counsel (as she pointed out) and, in the two years subsequent to this correspondence, no-one in the NMC was able to locate a copy in the files.

9.13 Before we reviewed the trail of emails, we asked Lawyer A if she was involved in putting together the first letter to Mr A. She told us:

"Yes, I remember being asked. I put something like bullet points together, but not in that format other than how it was addressed. How it is worded exactly, I cannot assist you with.

Q. Okay, you did some bullet points. You sent them to [the former director of fitness to practise]?

A. From memory, I am sure they went to [the former director of fitness to practise]. I drafted something along the lines of 'We took the decision it wouldn't have assisted' and, process wise, they should have been in the papers. The very first one, so that is 31st March. That information came from me because [the

former director of fitness to practise] was with me, but I told [her] that this is what has happened. I have it on an email. It is not too late to put it before the panel, but I am reading this, and it is not assisting because the very issue that one of them is making is that the midwife is not identifiable, and there are two midwives, this refers to one, and it undermines our case in one way. I can see why [Mr A] wants it in, but I actually don't think this is going to assist. So that is what the information was, and I do remember drafting something for the complaint, which is more in my remit because complaints managers answer, generally speaking, even if it is signed off. I do remember doing something for the complaint around that, but anything else beyond that, I have no knowledge of.

Q. So, the 31st March letter you inputted in?

A. Yes, definitely. I wasn't aware that there was a second letter."

9.14 Having reviewed the email trail which indicated that Lawyer A wrote the first draft of the letter to Mr A, we reminded her that she had told us that she her involvement was small and she had only produced some bullet points. She responded:

"Yes, and that's right, because I say in that email that this is in no way a final draft of the response to [Mr A].

"That might be my recollection. I recollected it was more rough, I think, than it maybe might have been, but I do make it very clear that it is in no way a final draft."

Comment

It is clear that Lawyer A was the primary source for the incorrect assertion that the NMC had the Chronology before the hearing.

PSA letter

9.15 On 17 May 2016, the Professional Standards Authority wrote to the NMC about the cases of Nurse 1 and 2. As this was in the context of its power to appeal against NMC decisions (the 'section 29' process) the question of whether the Chronology should have been admitted in evidence was an important issue for them. The Professional Standards Authority has a statutory role to review decisions made by regulators about fitness to practise decisions. They said that they had "*identified deficiencies*" in the approach taken by the panel and the NMC. One of these concerns related to "*evidential material not obtained and/or adduced by the NMC*". They commented that:

"there was material in then NMC's possession in relation to these cases which was not provided to the panel, for example the father's near contemporaneous statement".

9.16 The NMC responded to the Professional Standards Authority on 20 May 2016 as follows:

"We understand this [the failure to use evidence in the NMC's possession] to refer to a chronology drawn up by Mr A at some point after the incident (it is not clear when).

- *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 Nurse 1. The chronology refers to "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 25th or 26th October 2008".*

Comment

This short passage from the letter to the Professional Standards Authority includes two statements that are incorrect:

The NMC did not give “active consideration” to including the Chronology in the bundle of documents as it did not have a copy in its possession.

The Chronology is dated, so it is incorrect to state that, “there was nothing to indicate when it was made.”

9.17 The letter was drafted by another senior lawyer. She told us that Lawyer A was her main source of information relating to the case. A meeting was held on 17 May 2016 attended by Lawyer A, the former director of fitness to practise, and the lawyer that drafted the letter. After the meeting, the lawyer that drafted the letter circulated a summary of the notes she took in the meeting. Her email said, *“I am sending them [the notes] over to [Lawyer A] for checking/amendment/addition”*.

9.18 The note included the inaccuracies discussed above (i.e. that active consideration was given to the Chronology and there is nothing to indicate when the Chronology was made).

9.19 Lawyer A replied, making a number of changes to the note. However, she did not make any comment about these points of inaccuracy. The text from this note was used in the final letter sent to the PSA.

9.20 Following this, a draft letter was then produced. The former director of fitness to practise subsequently wrote to the author of the letter and Lawyer A to say, *“Many thanks to you and [Lawyer A] for preparing this response so quickly”*. The lawyer writing the letter then circulated a draft of the letter saying, *“please find attached my draft letter of response to the PSA letter, which [Lawyer A] has approved”*.

Comment

Again, it appears that Lawyer A was the main source of inaccurate information regarding the Chronology in this letter.

Secretary of State letter

9.21 Following the Professional Standards Authority letter, the Secretary of State for Health wrote to the NMC on 7 June 2016 on matters relating to the Morecambe Bay investigation. The former chief executive replied for the NMC on 23 June. The letter referred to the concerns that the Professional Standards Authority had raised and commented in the following terms on the specific issue of the Chronology:

“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”

Comment

The inclusion of inaccurate information in a formal letter from the former chief executive of the NMC to the Secretary of State for Health is obviously concerning.

It is also noticeable that while the Professional Standards Authority was told that there was nothing to indicate when the Chronology was made, it was described to the Secretary of State as “near-contemporaneous”. Nevertheless, and somewhat contradictorily, the letter stated that “it was not clear” when it was made.

9.22 This begs the obvious question of why the NMC made these inaccurate statements.

The NMC's consideration of the Chronology

9.23 As we have noted, it was the understanding of the former chief executive of the NMC that the NMC had considered the Chronology before the hearing. She told us that there was "no question" about that:

"My impression was it was part of the case papers, it was actively considered, and a decision was taken not to use it."

9.24 As we have said, we do not believe that the NMC had a copy of the Chronology before Mr A sent it during the hearing in March 2016. The question then arises as to why the NMC said that it had considered the Chronology before the hearing, when this was not correct.

9.25 We asked the Lawyer A about the time in the hearing when she, and the NMC's counsel first saw the Chronology. She told us:

"She looked at it and said that won't assist. So then I assumed that she had [seen it before], but said it wouldn't assist, from my memory. This is only recollection but, to be honest, I didn't go into it too much with her because I was more concerned with do we think we need to put this in before the panel now because we need to hurry and get on with it and do it."

"I wasn't concerned about whether she had seen it or not or what was in her papers or not at that point, so I didn't probe that with her. I assumed she had it in her papers somewhere, and perhaps hadn't taken much notice of it, but I did not ask her that. I asked her 'Do you agree with me, I don't think there is any value in this?' because the panel were already out deciding on whether to throw the cases in, so there was urgency about actually getting them back in if we were going to do this, and also we would have to then say to the defence we are going to do that, and we would have to think about giving [Mr A] a ring and saying 'Okay, we are going to do it, but you need to understand they are probably going to recall you'. We needed to know, so that was the priority. I didn't care whether she had seen it before or not."

"I am assuming it probably was in the thousands of pages that she received but, right now, do we think we need to do anything about this. That was more the

conversation we had but, in fairness to her, I assumed that she probably had seen it, and had not put it in because I do remember originally we did talk about JT1 going in, which is the [Baby A] story, and originally we had it in but then, ultimately, decided not to put it in because we just thought it is going to lead to legal argument. It makes it very emotive. It is going to be quite difficult, and then if that goes out and [Mr A] gets wind of that, it is probably more difficult to then deal with that.

“We did not think it necessarily added anything because [Mr A] was going to come and give evidence to this panel anyway, so they would get the sense of what happened from him directly. I know that she had JT1, so I made an assumption that she probably did have this, but I did not ask her. I did not probe it because I was more concerned with are we going to put this in before the panel now.”

9.26 Lawyer A also told us that she assumed that the NMC had seen the Chronology. She told us:

“That is an assumption that we made because process wise normally all the evidence goes. That is what I was coming on to because I don’t think we had realised fully by that stage that we had never had it. So normally the process is you give the case presenter everything on all the files, and because she was presenting all the cases, so it was not just [Nurse 1 and 2], she did ... [Nurses, 3, 4, 5 and 6], we gave her everything. So I think where that comes from is that the process is we give the case presenter everything and, by that stage, we didn’t actually know that it wasn’t there.

Q. “When you did look at it, you did decide it was not worth putting it in, so it is a reasonable assumption that the person who looked at it had decided the same thing.

A. “Exactly, and I think that was an assumption we made at the time, that it was in the papers. Like I say, as you know now, it is so odd that through all of these various stages it was not picked up as missing. I do remember answering process wise how we instructed external and we said ‘We give them everything. They are our counsel. They receive everything’ and she definitely received everything because she had [Nurses 3 and 4], as well as [Nurse 1 and 2], which was the original

Capsticks stuff, so she received everything, but what we didn't know was that everything had this."

9.27 The former director of fitness to practise told us:

"I believed at that point it was part of the case papers in the broadest sense that our case presenter had, and that if it wasn't something we were relying on it would have therefore been because the lawyers took the view that it wasn't anything that would add to the live evidence that Mr and Mrs A were giving. That's all I mean by that..."

"That's the only seed that I can take back to why, reasonably, that's why we all thought we had it, because we looked and saw it being exhibited, 'ah, we had it, it doesn't add anything', we must have decided or we didn't include it because it didn't add anything. But I'm adding that altogether now to make a smooth curve..."

9.28 The former chief executive told us:

"My understanding, very clear recollection, talking to [the former director of fitness to practise] at the time - this time was a very emotional time for colleagues in fitness to practise, and Mr [A] - was that there were a number of things that he was concerned about, and the chronology was one of them, but the issue was whether we were using it as part of our case, not whether we actually had it."

Comment

At the hearing, the NMC's main concern about the chronology was whether it should be used as evidence. As it was referenced in Mr A's original statement, the NMC assumed when writing the letters that the Chronology was with the papers. As all the papers had gone to counsel for consideration, it followed from that assumption that the Chronology had gone too. The fact that counsel had specifically highlighted that the Chronology was missing appears to have been forgotten. Even allowing for that, it is poor practice that no-one actually went and checked the papers to see whether the Chronology was among them. The failure to do so meant that the original misunderstandings and errors were repeated.

Whether the Chronology was contemporaneous

9.29 As we have noted, the correspondence describes the degree to which the letter was contemporaneous in a number of ways. Lawyer A says that the Chronology is not contemporaneous in a strict legal sense:

“This is what he sent me, and I don’t think it is contemporaneous in the sense it is made at the time, and the reason for saying the contemporaneous thing is one of the points that the panel made when they threw out both cases - they did midwife 1’s first, but midwife 2’s went at full facts - is that they said they had two versions of what happened, and it was a long time ago. The only thing that was contemporaneous were the notes made by the midwives at the time, and [Mr A] considered this to be the same, and I said ‘It’s not the same because they made those notes as they were going along whilst he was there’”.

9.30 However, Lawyer A notes that this is not at all the same as saying that there is nothing to indicate when it was made. She told us about the PSA letter:

“When I was asked by the PSA about that, I said ‘I don’t think that’s correct’. What I told them is we never had this exhibited, so I don’t know where the version that he sent me ever came from, but that does not mean to say it is not clear when it was made, and I remember telling the PSA that is not right. What is right is it is clearly not made at the time. It is after the event. It is not verbatim notes as things were going on because why would you do that, you didn’t know anything was going to go wrong at that stage. If everything went right no-one would really do that.

9.31 Regarding the statement about the Chronology that there was “Nothing to indicate when it is made”, Lawyer A told us:

“With hindsight, that wasn’t clear. That was bad. What we should have said is something more that there was nothing to indicate it was contemporaneous to your meeting. It happened after the event. That was badly phrased and that is badly phrased, which I think we have already talked about. It is badly phrased because

what I think we were trying to get across is that it had a date on it and he sent it through to us, and it wasn't contemporaneous in a sense, but that was really poorly phrased."

Comment

There is obviously a significant difference from saying that a document is not strictly contemporaneous in the legal sense, to saying that it has nothing on it to indicate when it was made. The latter statement was, in this case, simply wrong.

Whatever the true explanation for this inaccuracy, it is poor practice that the process was so badly managed that no-one checked thoroughly or had a copy of the document in front of them when writing the letters.

Cultural issues

9.32 These events raise wider issues about the culture of the NMC at the time.

9.33 The PSA's 'Lessons Learned Review' noted that the NMC adopted a "*defensive approach*" and "*did not take information from the families seriously or engage with them properly*". They went on to say that:

"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".

9.34 We spoke to the chief executive who was in post at the time that the letters were written in 2016. She accepted that the NMC had not dealt well with situations like this in the past. She told us:

"Prior to 2014 the NMC just wasn't competent to deal with the complexity of a case like this, frankly, many cases. It was an organisation that had failed for years with its Fitness to Practise cases, and it was only when we got enough money and

attention, Fitness to Practise, that it started to get its act together, but that was six years after [Baby A] died.

9.35 In particular, the former chief executive accepts that the NMC did not handle the relationship with Mr A well. She told us that *“the way in which we communicated with him and the others was terrible”* She added:

“I can completely accept, from his point of view, he was just being treated like somebody who was on the receiving end of a process.”

9.36 The former chief executive accepted that the system did not encourage the NMC to take a *“holistic view”*:

“That’s not how the process is designed, it’s ‘what did [midwife 1] do on that day, what did [midwife 2] do on that day’, and it’s really fragmented, and if you are the person who has lost a child, you can’t make sense of it. I get that.”

9.37 She added:

“I think the NMC has probably learnt many, many, many lessons as a result of this.”

9.38 The former chief executive told us that in many ways these cases are unique:

“In terms of the complexity, and the number of people, and the number of external investigations, and the Police and the Coroner and the Health and Safety Executive, and then Bill Kirkup, and so it goes on. FTP processes are not designed for things like this, they are just not. There were many mistakes made, but I think our handling of not just Mr A but others was very poor, and I think the PSA quite rightly criticise us for that. There was no excuse for it, except that it was an organisation that really didn’t get its act together till 2014.

9.39 Following the PSA report, the NMC announced a number of measures to address these issues. The NMC announced the following in July 2018:

“The NMC is taking immediate steps to adopt a new person-centered approach to fitness to practise. This will ensure that patients and families are treated with compassion and respect, and that their concerns about nurses and midwives are properly addressed and listened to. The regulator has set up a Public Support Service and a network of 50 employee public support champions who are already starting to bring about change.

“The NMC is also improving the way it communicates with people to make sure that it is clear, empathetic, helpful and easy to understand - this includes a full review of all written correspondence.

“There will be improved information for patients, families and the public and NMC employees will receive training and support to identify vulnerable people and make sure they get the support they need. All those raising concerns will be treated as individuals to ensure that their needs are properly being met while better engagement with patient and public groups will mean their voices are always represented in the organisation’s work and plans for the future.”

9.40 The current chief executive of the NMC, Andrea Sutcliffe, told us:

“No one should have to experience what Mr and Mrs A went through. The NMC did not treat Mr A and his family in the way they deserved and had every right to expect. As a result, we made an awful situation even worse for them. Since the PSA Lessons Learned Review, the organisation has improved its approach with the introduction of the Public Support Service in particular. I recognise, that there is still further work for us to do and make sure we consistently treat everyone involved in our work with the respect, kindness and humanity they deserve.”

Comment

This review has only looked at a single case. It is not therefore possible for us to make general comments on the culture of the NMC. Nevertheless, what we have seen clearly fits with the pattern that the PSA describe of the NMC failing to take the needs of families and patients seriously. Indeed, we believe that this report provides a case study of that culture and exemplifies those failings. Fundamentally, the NMC did not

care for Mr and Mrs A as it should have, but rather had a narrow focus on process. Had the NMC's communication been better, it is possible that the issues that arose could have been avoided.

We note that the NMC has already taken steps to address some of these issues and would encourage them to prioritise that work.

R2 Recommendation

The NMC should make it a priority to ensure that it treats families and patients with respect and is honest and open with them.

Comment: responsibility for the errors

Having reviewed all the evidence, we have considered responsibility for the errors in the letters.

Clearly the cultural issues that we have discussed are important and those at the top of the organisation must take responsibility for them. It is the collective responsibility of leaders to set expectations of their employees and to act as exemplars of them. In this respect, the NMC at the time failed Mr and Mrs A.

With regards to the specifics of the letters, although some of them went out in the former chief executive's name, we do not believe that anyone of her seniority would have personally checked the factual details that were provided by her team. Further, we do not believe that it is realistic to expect a senior executive to do so. They must be able to rely on the veracity of what they are told by those staff closest to the issues.

There is no evidence that the former director of fitness to practise was the source of any of the inaccurate information. It is arguable that she should have checked some of the facts in the correspondence, but again as a director of the organisation she could quite reasonably expect to be given accurate information by the individuals closest to the case. The evidence shows that the former director of fitness to practise was given clear and definite advice which was inaccurate.

We are satisfied that Lawyer A was the source of the errors of fact made in the NMC's correspondence.

Team biographies

Peter Killwick

After graduating from Cambridge University, Peter worked in the IT industry for three years before spending the next two years travelling in Asia, the far east, Oceania, North America and Africa. For the subsequent 25 years, Peter has worked in consulting covering a variety of strategic and operational issues in a wide range of sectors including healthcare, automotive, financial services, manufacturing, retail, telecommunications and government. In Verita, Peter has a particular focus on the development and evolution of our diagnostic tools including the Organisational Resilience Assessment and Complaints diagnostic.

Kieran Seale

Kieran joined Verita in 2014. He is an experienced consultant with a passion for improving public services. Following a varied career encompassing local government, government agencies and the private sector, Kieran spent five years working in NHS commissioning. He was involved in the setting up of four central London Clinical Commissioning Groups, advising on areas such as governance, risk management and conflicts of interest. Legally qualified, he has wide experience of delivering solutions to governance issues in the NHS and outside. While at Verita he has led a review of a conflict of interest issue at a CCG for NHS England and has been involved in a number of investigations into meeting government targets for Emergency Department performance and referral to treatment times for acute trusts. He also manages Verita's work supporting the British Council and the Lottery Forum in handling complaints.

David Scott

David Scott is an experienced human resources director, having operated at board/executive level for 15 years in private and public sector organisations. He is effective in managing employee relations in challenging environments, and is highly skilled in delivering cultural and performance improvements in complex organisations. His most recent appointments include interim CEO of the Duke of Edinburgh's Award where he

remains a trustee, an executive level position at First Group Buses London, and between 2004 and 2005 interim director of workforce and strategic HR at Kent and Medway Strategic Health Authority.

Bethany Simpson

Bethany Simpson is a project and marketing manager at Verita. She has supported a variety of projects including an independent review into a trust's disciplinary process of an NHS nurse and a governance review into reporting radiography. Bethany has managed a review into the care and treatment of a patient and multiple level three investigations into complaints procedures for the Big Lottery Fund.

Terms of reference

Background

- 1 In May 2018, the Professional Standards Authority for Health and Social Care (PSA) published a [lessons learned review](#) of the NMC's handling of concerns about midwives' fitness to practise at Furness General Hospital. Paragraphs 3.34, 4.27 to 4.36, and 4.130 address the NMC's handling of a chronology prepared by Mr and Mrs A in November 2008, following the death of their son, Baby A, at Furness General Hospital.
- 2 In summary, the PSA's findings are:
 - (a) The chronology was referred to as 'Exhibit 2' in a witness statement taken by external solicitors on the NMC's behalf and signed by Mr A in May 2010.
 - (b) Although the NMC had copies of the witness statement, there is no documentary evidence that the chronology was in the NMC's possession until Mr A provided a copy while a panel hearing of the cases of Midwives 1 and 2 was underway in 2016.
 - (c) Shortly after the 2016 hearing, Mr A was told that the first time the NMC had seen the chronology was when he provided a copy during the hearing.
 - (d) The NMC's correspondence with the PSA and with the Secretary of State following the 2016 hearing was capable of being understood as saying the NMC had given full consideration to the chronology well before Mr A provided a copy during the hearing.
 - (e) The NMC has never addressed Mr A's questions about what happened to the chronology.
- 3 The NMC has accepted all the findings and lessons set out in the lessons learned review.

Scope

- 4 The NMC wishes to commission an independent audit to review the way it handled the chronology. The audit will focus on the NMC's systems and processes in order to establish what happened and to identify learning and opportunities for improvement.
- 5 The desired outcomes of the audit are:
 - (a) To explain what happened to the chronology between the points at which Mr A (i) signed his witness statement in May 2010; and (ii) provided a copy of the chronology during the 2016 hearing.
 - (b) To make recommendations for improving the NMC's approach to records management.
 - (c) To explain how any inconsistent and/or ambiguous accounts of what happened to the chronology came to be given publicly after the 2016 hearing.
 - (d) To make recommendations to ensure accounts given publicly are accurate, transparent, and consistent.

List of interviewees

The former chief executive of NMC

Lawyer A, a senior Lawyer at NMC

Another former senior lawyer at NMC

Head of investigations at NMC

Former director of fitness to practise at NMC

Former assistant director for legal services at NMC

Assistant director, office of the chairman and chief executive, NMC

Partner at Capsticks

Senior associate and partner at Blake Morgan (by correspondence)

Document list

Baby A's story
Chronology of events
Witness statements
Witness exhibits
Hearing transcripts
Press coverage 2016
Previous reports
Trust guidelines
Mr A's October 2009 statement
Documents from Capsticks
Documents from Morgan Cole
Letters from family
Letters from NMC
Letters to former Secretary of State for Health
Letters to professional standards authority
Previous letters of complaint
Correspondence between family and trust