Terms of reference for independent review

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.

(e) To report on any other relevant matters relating to the NMC's handling of the chronology that may arise.